Health Safety Net Trust Fund
2008 Payment Methods

Division of Health Care Finance and Policy

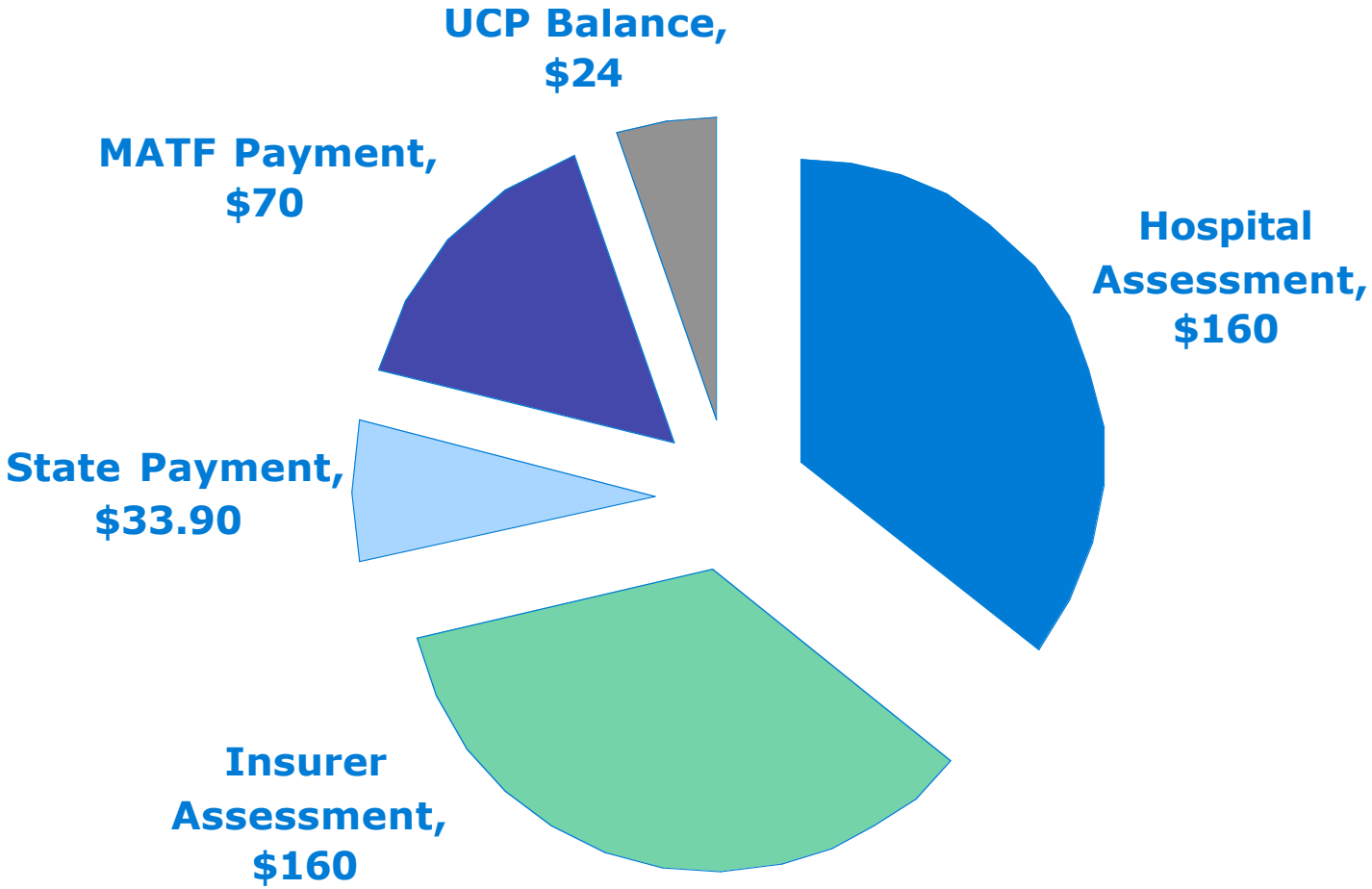
November 27, 2007

DHCFP

Topics

- HSN funding and spending overview
- Chapter 58 requirements
- Payment methods
  - Inpatient
  - Outpatient
  - Emergency Bad Debt
- Anticipated changes for FY09
- Questions & answers

HSN Funding in FY2008 is approx. $448 million



$ in millions

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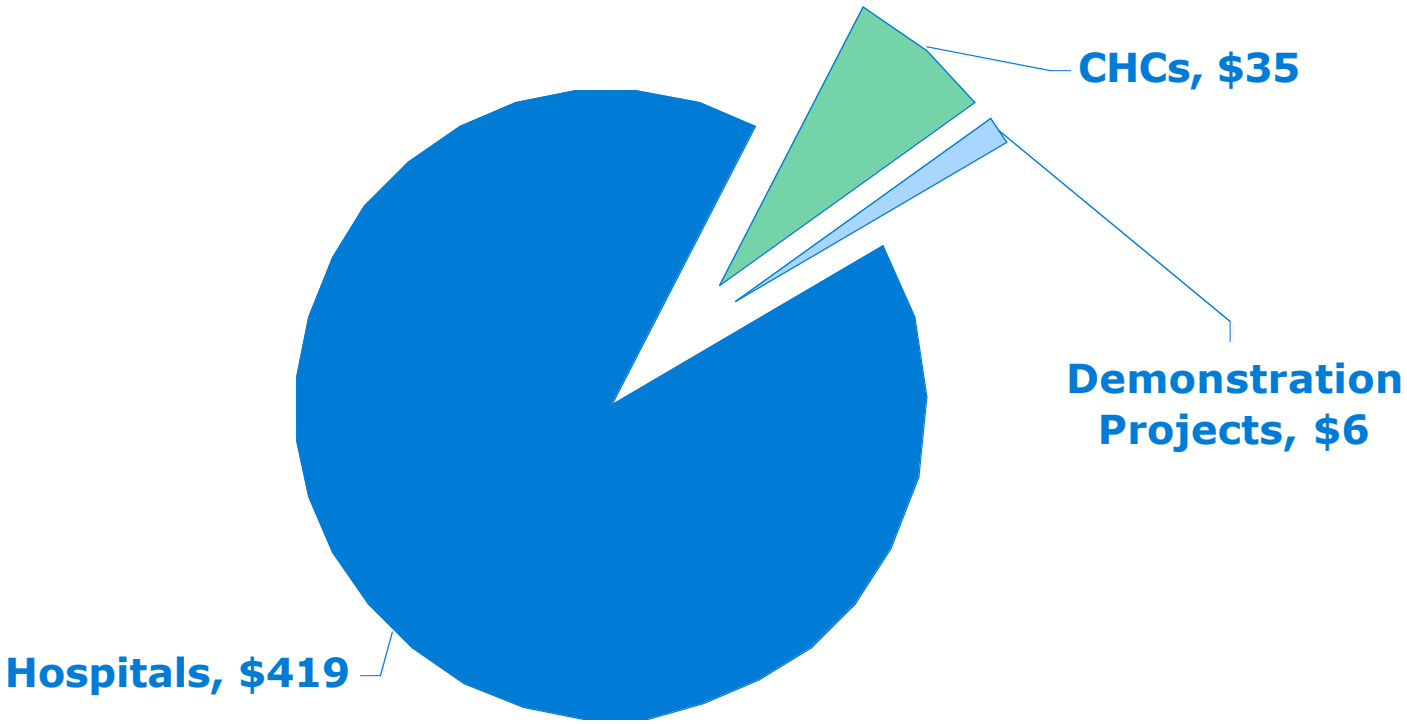
Projected HSN Spending in FY2008 is approx. $460 million



$ in millions

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Chapter 58 Mandates

- The health care reform statute specified the payment methods to be used for Health Safety Net services
- Hospital services to be paid using Medicare payment principles, based on actual claims
- Rates can be adjusted for:
  - Service and case mix differences
  - Services for which Medicare does not establish a price (Rx drugs)
- Payments cannot exceed HSN funding
  - If a shortfall in annual funding is anticipated, the shortfall is to be allocated using the "greater proportional need" method

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FY2008 Hospital Payment Model

- Interim Payment System
  - Monthly payment system based on Medicare payment rates
  - Effective 10/1/2007 – 3/31/2008
  - Will be reconciled after close of period

- Standard Payment System
  - Per visit and per discharge payments based on actual claims of service and Medicare payment levels
  - Effective 4/1/2008

- Pharmacy
  - MassHealth Pharmacy On-line Payment System (POPS)

Hospital Payments

- Using Medicare pricing principles, DHCFP calculated rates for each of the following service types:
  - Inpatient:
    - Medical (per discharge)
    - Psychiatric (per day)
    - Rehabilitation (per day)
    - Emergency Bad Debt: Medical
    - Emergency Bad Debt: Psychiatric
  - Outpatient:
    - Payment per day of service
    - Emergency Bad Debt

Rate Methods

- Inpatient Medical-Surgical Per Discharge
  - PFY2006 claims, grouped using Medicare DRG grouper, standardized per discharge amount * hospital-specific casemix
  - FFY07 rates, updated for inflation

- Inpatient Psychiatric Per Day
  - PFY2006 claims, used Medicare per diem rates, adjusted for hospital-specific factors
  - Used 2008 rates

Rate Methods (cont'd)

- Outpatient Services
  - Could not do APC grouping due to coding issues
  - Using PFY2006 claims, applied ratio of Medicare payment to charges, determined OP per visit rate, adjusted for inflation
- Emergency Room Bad Debt
  - Same method as above for inpatient and outpatient, separate standard rates
- Outpatient Pharmacy
  - Claims submitted through MassHealth POPS system
  - Includes all MassHealth rules for covered services, prior authorization
  - Payments based on MassHealth fee schedule

Transition Payment Period

- October 1, 2007 – March 31, 2008
  - Monthly payments based on proposed rates times projected volume
  - Projected volume assumed that much of the former UCP volume will be reduced due to increased enrollment in CommCare
  - Rx payments included in October, November, December, January payments based on historical claims
  - Rx payments will be paid using POPS method February and forward
  - Will be reconciled to applicable volume
- April 1, 2008
  - Payments based on actual volume

HSN 2008 Funding Shortfall

- CHCs receive priority payments from HSN
  - No shortfall burden for CHCs
- Hospitals share shortfall burden
  - Allocated based upon "Greater Proportional Need"
  - DSH hospitals receive floor of 85% of FFS rate payments
  - Shortfall estimates will be updated to reflect actual utilization when available

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HSNO Billing Rules

- Claims are to be paid on date of service, not date of write-off
  - Except emergency bad debt claims and retro claims
- Claims generally must be submitted 90 days from date of service
  - 90 days from date of primary payer's EOB
- If determined eligible after date of service, claims must be submitted within 90 days of eligibility determination

HSNO Billing Rules

- Emergency bad debt submitted no earlier than 120 days after date of service
  - Inpatient claims require submission of additional evidence
- Medical Hardship claims must be submitted within 30 days after eligibility determined
- Pharmacy claims within 90 days of date of service

Ongoing Monitoring

- DHCFP plans ongoing monitoring activity:
  - Submission of additional information from Hospitals re: uncompensated care
  - Reports to spot unusual trends, such as unbundling of services, to make adjustments as needed
  - Ongoing volume reporting

Anticipated Changes, FY09 and Forward

- After the transition to an improved claims system is complete, DHCFP will be moving closer to the Medicare format:
  - Ambulatory Patient Classification (APC) fee schedule
  - MassHealth fee schedules for non-Medicare covered services (e.g. dental)
  - Inpatient DRG model, update casemix data more frequently or on a per-discharge basis

Resources Available

- Payment regulations available on our website
  - 114.6 CMR 13.00: Health Safety Net Eligible Services
  - 114.6 CMR 14.00: Health Safety Net Payments and Funding
- FAQs and payment information available on our website
- Help desk (800) 609-7232
- Website http://www.mass.gov/dhcfp

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